IV. SPECIFIC DOUBLE COVERAGE ACTIONS

A. TRICARE and Medicare

1. Medicare Always Primary to TRICARE

Certain persons over sixty-five (65) years of age who were not previously entitled to Medicare Part A, "Hospital Insurance Benefits," became eligible to enroll in Part A after June 30, 1973, under the premium Health Insurance provision of the 1972 Amendment to the Social Security Act. Entitlement to Part A secured under these circumstances does not result in a loss of TRICARE benefits. With the exception of services provided by a resource sharing provider in an MTF, in any double coverage situation involving Medicare and TRICARE, Medicare is always primary. When services are provided by a resource sharing provider in an MTF, the double coverage procedures are waived and TRICARE is primary payer. This applies only to Medicare. All other payers remain primary to TRICARE.

2. Coordination with Part A, Medicare

Virtually all Part A, Medicare, claims are submitted by participating providers. Because of the Part A payment mechanisms, the provider knows, at the time the claim is submitted, the amount that will not be paid by Medicare. This amount is then billed to the beneficiary or to the beneficiary's secondary coverage. It is this amount that TRICARE will pay along with any services denied by Medicare which are covered by TRICARE. In cases where the TRICARE allowable amount (or the negotiated rate) is less than the Medicare payment, the beneficiary will have no liability for the Medicare deductible and coinsurance. When the beneficiary has exhausted his or her Part A benefits for a benefit period, TRICARE will pay the full benefit amount for covered services.

3. Coordination with Part B, Medicare

With the exception of prescription drug claims, which are not a Medicare benefit, a TRICARE claim must be accompanied by a copy of the appropriate Explanation of Medicare Benefits (EOMB) form. When Medicare paid its benefits directly to the beneficiary, the secondary share paid by TRICARE will be calculated according to the procedures in Section III.B., of this chapter. When Medicare paid benefits directly to the provider, TRICARE may pay only the Medicare deductible, if any, the Medicare coinsurance, and any services which were denied by Medicare and which are covered by TRICARE. In cases where the TRICARE allowable amount (or the negotiated rate) is less than the Medicare payment, the beneficiary will have no liability for the Medicare deductible and coinsurance. TRICARE may not pay the difference between the billed charge and the Medicare allowed charge, since to do so would place the provider in violation of Medicare's assignment agreement.

B. TRICARE and Medicaid

1. Medicaid Not Double Coverage

Medicaid is not considered a double coverage plan. When a TRICARE beneficiary is also eligible for Medicaid, TRICARE is always primary for all classes of beneficiary.

2. Medicaid Payments Made in Error

a. If Medicaid erroneously pays benefits as a primary payor on behalf of a TRICARE beneficiary, the contractor will reimburse the state Medicaid agency. *See Policy Manual, Chapter 13, Section 5.1.*

b. ***Reserved***

C. Maternal and Child Health Program/Indian Health Service

Eligibility for health benefits under either of these two Federal programs is not considered to be double coverage. (See the Policy Manual, Chapter 13, Section 12.1.)

D. TRICARE and Veterans Administration

1. *Reserved*

2. Veterans Benefits

Eligibility for health care through the Veterans Administration for a service-connected disability is not considered double coverage. The beneficiary may choose to use either TRICARE or Veterans benefits, providing he/she is TRICARE eligible. (The VA sponsor of a TRICARE beneficiary is not eligible for care under either TRICARE or CHAMPVA.) However, TRICARE will not duplicate payments made by or authorized to be made by the Veterans Administration for treatment of a service-connected disability. (See OPM Part Two, Chapter 1, for handling cases in which a dual payment is suspected.)

E. TRICARE and Worker's Compensation

TRICARE benefits are not payable for work-related illness or injury which is covered under a Worker's Compensation program. When Worker's Compensation is involved, the following rules apply:

1. No Option

The TRICARE beneficiary may not waive his or her Worker's Compensation benefits in favor of using TRICARE benefits. The beneficiary must apply for Worker's Compensation benefits. Failure to apply does not change the TRICARE exclusion.

2. *Review* of Claims

a. If the claim indicates that an illness or injury might be work-related, the contractor must develop to determine whether the beneficiary has applied for Worker's Compensation. If the beneficiary has applied but a determination has not yet been made, see Section IV.E.5. below. If the beneficiary has not yet applied, the contractor will explain the requirement to do so and will deny the claim.

b. The beneficiary must be told that the claim may be resubmitted if the Worker's Compensation claim is denied or if there is an extensive delay in the determination. If the Worker's Compensation claim is denied, the TRICARE contractor will process the claim routinely. When necessary, the TRICARE contractor will coordinate with

the Worker's Compensation agency to establish the status of a Worker's Compensation claim.

3. Dispute as to Work-Related

The agency which has authority to determine "work-related" illness or injury in a case (as designated by the applicable Worker's Compensation law) is the final authority in all such determinations. If a disputed case is determined not to be work related (i.e., a substantive determination rather than a decision that Worker's Compensation benefits are not payable for technical reasons), TRICARE shall assume liability for extension of benefits.

4. Exhaustion of Worker's Compensation Benefits

If a TRICARE beneficiary exhausts available Worker's Compensation benefits, TRICARE will provide benefits for covered services under the following conditions:

a. Documentation Required

The beneficiary must furnish written documentation to the contractor that the Worker's Compensation benefits have been exhausted.

b. Lump-Sum Settlement

If the Worker's Compensation benefits were paid in the form of a lump-sum settlement, TRICARE will not pay benefits for the work-related illness/injury until the beneficiary furnishes written proof that he or she has incurred medical expenses equal to the amount of the award designated for medical expenses. If the award was not distributed specifically between medical expenses and damages, the beneficiary must furnish proof that he or she has incurred medical expenses equal to the full amount for the award. (The incurred medical expenses need not represent TRICARE covered services if they are related to the work-related illness or injury.)

5. Special Assistance for Extensive Delays

The contractor should extend benefits in Worker's Compensation cases which involve an extensive delay by the state agency in reaching the Worker's Compensation determination. Benefits may also be paid when an unusual delay occurs because the beneficiary elects to appeal an adverse decision by the Worker's Compensation agency. If the beneficiary makes a request for this special assistance, the contractor should obtain an agreement from the Worker's Compensation agency that the agency will reimburse it for any benefits paid, up to the amount of the award, in the event of a determination that the beneficiary is entitled to Worker's Compensation benefits.

F. TRICARE and Supplemental Insurance Plans

1. Not Considered Double Coverage

Supplemental or complementary insurance coverage is a health insurance policy or other health benefit plan offered by a private entity to a TRICARE beneficiary, that primarily is designed, advertised, marketed, or otherwise held out as providing payment for expenses incurred for services and items that are not reimbursed under TRICARE due to program limitations, or beneficiary liabilities imposed by law. TRICARE recognizes two types of supplemental plans, general indemnity plans and those

offered through a direct service health maintenance organization (HMO). Supplemental insurance plans are not considered double coverage. TRICARE benefits will be paid without regard to the beneficiary's entitlement to supplemental coverage.

2. Income Maintenance Plans

Income maintenance plans pay the beneficiary a flat amount per day, week or month while the beneficiary is hospitalized or disabled. They usually do not specify a type of illness, length of stay, or type of medical service required to qualify for benefits, and benefits are not paid on the basis of incurred expenses. Income maintenance plans are not considered double coverage. TRICARE will pay benefits without regard to the beneficiary's entitlement to an income maintenance plan.

3. Other Secondary Coverage

Some insurance plans state that their benefits are payable only after payment by all government, Blue Cross/Blue Shield and private plans to which the beneficiary is entitled. In some coverages, however, it provides that if the beneficiary has no other coverage, it will pay as a primary carrier. Such plans are double coverage under TRICARE law, regulation and policy and are subject to the usual double coverage requirements.

G. School Coverage - School Infirmary

TRICARE benefits shall be paid for covered services provided to students by a school infirmary provided that the school imposes charges for the services on all students or on all students who are covered by health insurance.

H. TRICARE and Health Maintenance Organizations

See the Policy Manual, Chapter 13, Section 13.1.

I. TRICARE and Preferred Provider Organizations

See the Policy Manual, Chapter 13, Section 10.1.

J. Double Coverage and the Program for Persons with Disabilities *(PFPWD)*

1. Program for Persons with Disabilities claims are subject to double coverage provisions.

2. If a Program for Persons with Disabilities *(PFPWD)* beneficiary is eligible for other federal, state, or local assistance to the same extent as any other resident or citizen, TRICARE benefits are payable only for amounts left unpaid by the other program, up to the TRICARE maximum of $1,000 per month. The beneficiary may not waive available federal, state, or local assistance in favor of using TRICARE.

K. Privately-Purchased, Non-Group Coverage

Privately-purchased, non-group health insurance coverage is considered double coverage.

L. Liability Insurance

If a TRICARE beneficiary is injured as a result of an action or the negligence of a third person, the contractor must develop the claim(s) for potential third party liability (TPL). (See OPM Part Two, Chapter 5, Section V.) The contractor shall pursue the Government's subrogation rights under the Federal Medical Care Recovery Act, if the other health insurance, including auto or home owner's medical insurance, no-fault auto, or uninsured motorist coverage does not cover all expenses.

M. TRICARE and Pre-Paid Prescription Plans

If the beneficiary has a "pre-paid prescription plan," where the beneficiary pays only a "flat fee" no matter what the actual cost of the drug, the contractor shall cost-share the fee and not develop for the actual cost of the drug, since the beneficiary is liable only for the "fee."

N. TRICARE and State Victims of Crime Compensation Programs

Effective September 13, 1994, State Victims of Crime Compensation Programs are not considered double coverage. When a TRICARE beneficiary is also eligible for benefits under a State Victims of Crime Compensation Program, TRICARE is always the primary payer over the State Victims of Crime Compensation Programs.

O. Surrogate Arrangements

Contractual arrangements between a surrogate mother and adoptive parents are considered Other Coverage. If brought to the contractor's attention, the requirements of OPM Part Two, Chapter 5, Section V.B.10. would apply.